OPTIMUS MEDICAL GROUP

870 Market St. Suite 600, San Francisco, CA 94102
o 415-397-0700 fax 415-397-6805
45 Castro St. Suite 325, San Francisco, CA 94114
o 415-863-3366 fax 415-552-4565

PATIENT REGISTRATION

Name
Last First Middle

Home Address
Street City State Zip Code

Mailing Address (if different from above)
Street City State Zip Code

SOCIAL SECURITY NO.: **DATE OF BIRTH:**

Gender Identity: ☐ M ☐ F ☐ TG ☐ Non-binary Home Phone: Work Phone:

Cell Phone: **Text reminders:** ☐ Y ☐ N **Email Address:**

Can we leave a message/lab results at home? ☐ Y ☐ N **At Work?** ☐ Y ☐ N **On Cell ?** ☐ Y ☐ N

Employer: Occupation:

Name of Significant Other: Phone:

Emergency Contact: Phone:

Durable Power of Attorney name: Physician Orders for Life-Sustaining Treatment? ☐ Y ☐ N Request Form ☐ Y ☐ N

How were you referred to this office?

Primary Insurance Co. _____ Secondary Insurance Co. _____

Plan type ☐ HMO ☐ PPO ☐ Other _____

Name of Insured (if different from patient)_____

Insured's (if different from patient) DOB: _____ ID #_____

CO-PAY? ☐ Y ☐ N **Amount:**

Pharmacy: Phone: Fax:

Mail Order Pharmacy: Phone: Fax:

I understand that I am responsible for my copay or coinsurance at the time of visit and acknowledge that I will be billed a fee for Copay billed to my home. **THERE IS A $75 NO SHOW FEE FOR MISSED OR CANCELED WITH LESS THAT 24 HOUR NOTICE**
Assignment of Benefits: I, the undersigned, have insurance coverage with the above named carrier and assign directly to Dr. Shawn K. Hassler all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that if this or any other visit precedes the effective date of my enrollment in my insurance company, I will be held responsible for any and all fees incurred, I hereby authorize Optimus Medical Group, Allscripts, CHMB, and AMP Smart Business to release all information necessary to secure the payments of benefits. **DELINQUENT ACCOUNTS ARE REFERRED TO COLLECTIONS**

Signature_____ Date_____

CONFIDENTIAL

HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

BIRTHPLACE _____ BIRTHDATE _____ AGE _____ OCCUPATION _____

MAIN REASON FOR VISIT TODAY? _____

TODAY'S CURRENT COMPLAINTS/ CONCERNS? _____

MEDICATIONS/ VITAMINS SUPPLEMENTS

PLEASE LIST ALL DRUGS, VITAMINS AND DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING. IF POSSIBLE, LIST STARTING DATE AND DOSAGE.

MEDICATIONS	DATE	DOSE	NUTRITIONAL SUPPLEMENTS	DOSE

	YES	NO	EFFECT		EFFECT
PENICILLINS	☐	☐		OTHER:	
SULFA	☐	☐		OTHER:	
IODINE	☐	☐			
SHELL FISH	☐	☐			

LIST ALL HOSPITALIZATIONS, OPERATIONS (INCLUDING PLASTIC SURGERY) AND/OR SERIOUS INJURIES.

YEAR	HOSPITALIZATION-OPERATION-INJURY	HOSPITAL & LOCATION

CONFIDENTIAL - DO NOT PHOTOCOPY

NEW PATIENT MEDICAL HISTORY AND HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

SEXUAL IDENTITY/ ORIENTATION:

[ ] STRICTLY HETEROSEXUAL
[ ] STRICTLY HOMOSEXUAL
[ ] UNKNOWN
[ ] TRANSGENDER
[ ] BISEXUAL
[ ] NOT SEXUALLY ACTIVE

PSYCHOLOGICAL HISTORY:

	PRESENTLY	IN THE PAST
PSYCHOTHERAPY	[ ]	[ ]
ANTIDEPRESSANTS	[ ]	[ ]

SPECIFY: _____

OTHER PSYCHIATRIC MEDICATIONS	[ ]	[ ]

SPECIFY: _____

HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL FOR A PSYCHOLOGICAL EVALUATION? YES [ ] NO [ ]

IF YES, PLEASE SPECIFY WHEN AND THE DURATION OF STAY FOR EACH EPISODE: _____

_____

_____

SMOKING (CIGARETTES):

PAST USE:	PRESENT USE
_____PACKS/DAY	_____PACKS/DAY
_____YEARS TOTAL	_____YEARS TOTAL

ALCOHOL:

[ ] NONE
[ ] I SELDOM DRINK
[ ] I HAVE A DRINK ABOUT 3-5 TIMES PER WEEK
[ ] I DRINK DAILY

PLEASE STATE WHAT TYPE(S): _____

RECREATIONAL DRUG USE:

PLEASE DISCUSS WITH YOUR PROVIDER.

EXERCISE:

GYM?

CHECK ONE OF THE FOLLOWING STATEMENTS:

[ ] I MAKE NO EFFORT TO OBTAIN REGULAR EXERCISE
[ ] I LIVE AN ACTIVE LIFE AND GET MY WORKOUTS FROM DAILY LIVING ACTIVITIES SUCH AS WALKING, HIKING
[ ] I MAKE A MODEST EFFORT TO OBTAIN REGULAR EXERCISE (1-3X WEEKLY)
[ ] OBTAIN REGULAR EXERCISE 3 TO 5X PER WEEK (AT LEAST 30 MINUTES/SESSION)
[ ] OBTAIN REGULAR EXERCISE > 5X PER WEEK (AT LEAST 30 MINUTES/SESSION)

COMMENTS: _____

FAVORITE EXERCISE ACTIVITIES	DURATION	TIMES/WEEK
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME: DATE:

ILLNESSES & MEDICAL PROBLEMS (WITHIN PAST YEAR OR PRESENTLY):

	YES	NO
DIZZY SPELLS/VERTIGO	[ ]	[ ]
GLAUCOMA	[ ]	[ ]
EYE PROBLEMS	[ ]	[ ]
EAR TROUBLE	[ ]	[ ]
SINUS TROUBLE	[ ]	[ ]
DEAFNESS OR DECREASED HEARING	[ ]	[ ]
REPEATED NOSE BLEEDS	[ ]	[ ]
CHRONIC NASAL OBSTRUCTION	[ ]	[ ]
SWELLING IN NECK	[ ]	[ ]
ASTHMA	[ ]	[ ]
BRONCHITIS	[ ]	[ ]
EMPHYSEMA	[ ]	[ ]
PNEUMONIA	[ ]	[ ]
TUBERCULOSIS	[ ]	[ ]
OTHER LUNG PROBLEMS	[ ]	[ ]
SEASONAL ALLERGIES	[ ]	[ ]
HIGH BLOOD PRESSURE	[ ]	[ ]

	YES	NO
LOW BLOOD PRESSURE	[ ]	[ ]
BLEED EASILY	[ ]	[ ]
BRUISE EASILY	[ ]	[ ]
BLEEDING DISORDER	[ ]	[ ]
ANEMIA	[ ]	[ ]
HEART ATTACK	[ ]	[ ]
HEART MURMUR	[ ]	[ ]
ANKLE SWELLING	[ ]	[ ]
OTHER HEART CONDITION	[ ]	[ ]
STOMACH/DUODENAL ULCERS	[ ]	[ ]
COLITIS	[ ]	[ ]
DIVERTICULOSIS	[ ]	[ ]
OTHER BOWEL PROBLEMS	[ ]	[ ]
HEPATITIS	[ ]	[ ]
MONONUCLEOSIS	[ ]	[ ]
GALL BLADDER TROUBLE	[ ]	[ ]
STROKE	[ ]	[ ]
CONVULSION/SEIZURES	[ ]	[ ]
SCARLET FEVER	[ ]	[ ]

	YES	NO
ARTHRITIS	[ ]	[ ]
DIABETES	[ ]	[ ]
TROUBLE W/ ANESTHESIA	[ ]	[ ]
PARALYSIS	[ ]	[ ]
CANCER	[ ]	[ ]

YEAR AND TYPE OF CANCER _____

_____

_____

WOMEN ONLY

TENDER BREASTS	[ ]	[ ]
DISCHARGE FROM NIPPLES	[ ]	[ ]
LUMPS OR RECENT CHANGE IN SIZE	[ ]	[ ]
FIBROCYSTIC DISEASE	[ ]	[ ]
MENSTRUAL PROBLEMS	[ ]	[ ]
LAST MAMMOGRAM	[ ]	[ ]
YEAR _____ NORMAL	[ ]	[ ]
LAST PAP SMEAR	[ ]	[ ]
YEAR _____ NORMAL?	[ ]	[ ]

DATE YOU BEGAN YOUR LAST MENSTRUAL PERIOD:

FAMILY HISTORY:

	YES	NO
TUBERCULOSIS	[ ]	[ ]
ASTHMA	[ ]	[ ]
GLAUCOMA	[ ]	[ ]
CANCER	[ ]	[ ]

	YES	NO
DIABETES	[ ]	[ ]
RHEUMATOID ARTHRITIS	[ ]	[ ]
HEART DISEASE	[ ]	[ ]
HIGH BLOOD PRESSURE	[ ]	[ ]

	YES	NO
LOW BLOOD PRESSURE	[ ]	[ ]
BLEEDING TENDENCY	[ ]	[ ]
BLOOD DISORDERS (SICKLE CELL ANEMIA, ETC.)	[ ]	[ ]
ULCER DISEASE	[ ]	[ ]

PHYSICAL AILMENTS:

	YES	NO
HEADACHES	[ ]	[ ]
NECK PAIN	[ ]	[ ]
SHOULDER PAIN	[ ]	[ ]
IRRITABILITY	[ ]	[ ]
INSOMNIA	[ ]	[ ]
NERVOUSNESS	[ ]	[ ]
BACK PAIN	[ ]	[ ]

	YES	NO
CHEST PAINS	[ ]	[ ]
SHORTNESS OF BREATH	[ ]	[ ]
WHEEZING	[ ]	[ ]
TIREDNESS	[ ]	[ ]
POOR APPETITE	[ ]	[ ]
WEIGHT LOSS	[ ]	[ ]
WEIGHT GAIN	[ ]	[ ]

	YES	NO
DIZZINESS	[ ]	[ ]
DIARRHEA	[ ]	[ ]
CONSTIPATION	[ ]	[ ]
BLOODY STOOLS	[ ]	[ ]
INDIGESTION	[ ]	[ ]
GAS (DYSPEPSIA)	[ ]	[ ]
HEARTBURN	[ ]	[ ]

MENTAL/ EMOTIONAL AILMENTS

	YES	NO
DEPRESSION	[ ]	[ ]
ANXIETY	[ ]	[ ]

	YES	NO
MOOD SWINGS	[ ]	[ ]
HELPLESS FEELINGS	[ ]	[ ]

	YES	NO
INDECISION	[ ]	[ ]
HEARTACHE	[ ]	[ ]

COMMENTS: _____

IS YOUR PARTNER, SPOUSE, OR ANYONE IN YOUR FAMILY ABUSING OR HARMING YOU? [ ] YES [ ] NO

NAME:_____ DATE:_____

STRESS:

OCCUPATION: PRIOR OCCUPATIONS:

HOURS WORKED PER WEEK: VACATION TIME PER YEAR:

JOB SATISFACTION RATING: [ ] GREAT [ ] OK [ ] FAIR [ ] POOR

FRIENDS:

[ ] I HAVE MANY WARM AND CLOSE RELATIONSHIPS
[ ] I HAVE MANY FRIENDS
[ ] I HAVE A FEW CLOSE FRIENDS
[ ] I DON'T HAVE ANY REAL CLOSE FRIENDS

HOW MANY TIMES HAVE YOU MOVED IN THE PAST TWO YEARS?

LIST STATES/ COUNTRIES WHERE YOU HAVE LIVED:

PLEASE EXPLAIN ANY RECENT STRESSFUL EVENTS:

STRESS REDUCTION ACTIVITIES (I.E., EXERCISE, MEDITATION, YOGA, RELIGION, ETC.):

THE FOLLOWING INFORMATION IS HELD IN THE STRICTEST CONFIDENCE.

DATE OF LAST HIV TEST: RESULT:

CONFIDENTIAL - DO NOT PHOTOCOPY

PLEASE COMPLETE THE FOLLOWING PAGE ONLY IF YOU ARE HIV(+).

PLEASE COMPLETE THIS PAGE ONLY IF YOU ARE HIV(+).

NAME: _____ DATE: _____

CURRENT HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

	DATES		DATES
[ ] FEVERS	_____	[ ] COUGHING	_____
[ ] NIGHT SWEATS	_____	[ ] SHORTNESS OF BREATH	_____
[ ] FATIGUE	_____	[ ] CHEST PAIN	_____
[ ] UNINTENTIONAL WEIGHT LOSS	_____	[ ] DIARRHEA	_____
[ ] SWOLLEN LYMPH NODES	_____	[ ] NAUSEA AND VOMITING	_____
[ ] VISUAL CHANGES	_____	[ ] URINARY TRACT PROBLEMS	_____
[ ] HEADACHES	_____	[ ] DECREASED LIBIDO/IMPOTENCE	_____
[ ] RECURRENT SINUS PROBLEMS	_____	[ ] VAGINAL INFECTIONS	_____
[ ] ORAL (MOUTH) PROBLEMS	_____	[ ] NUMBNESS/TINGLING OF ARMS OR LEGS	_____
[ ] SWALLOWING PROBLEMS	_____	[ ] LOSS OF BALANCE	_____
[ ] SKIN RASHES /SORES	_____	[ ] MEMORY LOSS OR CONFUSION	_____

PAST MEDICAL HISTORY

[ ] ORAL CANDIDIASIS (THRUSH)	_____	[ ] PNEUMOCYSTIS PNEUMONIA	_____
[ ] HAIRY LEUKOPLAKIA	_____	[ ] BACTERIAL PNEUMONIA	_____
[ ] ORAL HERPES INFECTIONS	_____	[ ] TUBERCULOSIS	_____
[ ] GENITAL WARTS	_____	[ ] KAPOSI'S SARCOMA	_____
[ ] GONORRHEA	_____	[ ] MAI/ MAC	_____
[ ] INTESTINAL PROBLEMS	_____	[ ] HIGH CHOLESTEROL	_____
TYPE	_____	[ ] CORONARY ARTERY DISEASE	_____
[ ] HEPATITIS A	_____	[ ] LAST TB SKIN TEST	_____
[ ] HEPATITIS B	_____	[ ] OTHER:	_____
[ ] HEPATITIS C	_____	[ ] OTHER:	_____
[ ] CMV RETINITIS / COLITIS	_____	[ ] EXPOSURE TO TUBERCULOSIS	
[ ] SYPHILIS		[ ] LYMPHOMA	
[ ] GENITAL OR RECTAL HERPES		[ ] CRYPTOCOCCAL MENINGITIS	_____

HAVE YOU EVER BEEN DIAGNOSED WITH INTESTINAL PARASITES? [ ] YES [ ] NO

WHEN: _____ WHICH ONES: _____

HOW WERE THEY TREATED? _____

RECENT LABORATORY VALUES

DATE _____ VIRAL LOAD (PCR OR BDNA) _____ HELPER T-CELL NUMBER (CD4)_____

LIST ALL PRIOR MEDICATION REGIMENS AND DATES

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

DO YOU HAVE A SIGNIFICANT OTHER? [ ] YES HOW LONG: _____ NO [ ]

DO YOU HAVE CLOSE CONTACT WITH YOUR FAMILY? [ ] YES [ ] NO

ARE YOU SEEING A THERAPIST OR IN A SUPPORT GROUP? [ ] YES [ ] NO

NAME: _____ PHONE: _____

WHERE HAVE YOU TRAVELED WITHIN THE PAST THREE YEARS (OUTSIDE THE USA)? WHEN? _____

OPTIMUS MEDICAL GROUP

Patient Consent Form

The Health Insurance Portability and Accountability Act of 1996 (**HIPPA**) established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patients to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding, treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

There are several circumstances in which we may use and disclose health information about you. **FOR TREATMENT.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. **FOR PAYMENT.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. **APPOINTMENT REMINDERS.** We may contact you as a reminder that you have an appointment for treatment or medical care at our office.
There are several **SPECIAL SITUATIONS** we may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations. **TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **REQUIRED BY LAW.** We will disclose health information about you when required to do so by federal, state or local law. **RESEARCH.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at the office.

You may refuse to consent to the use or disclosure of your personal health information, but this MUST be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you Personal Health Information. If you choose to give consent n this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to Paul Gilea our HIPAA Compliance Officer. You have the right to review our Notice of Privacy Practices, to request restrictions and revoke consent in writing.

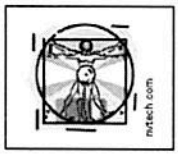
_____ _____

Print Name Date

_____

Signature

SHAWN HASSLER, MD
870 MARKET STREET, SUITE #600
SAN FRANCISO, CA 94102
415-397-0700



COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information has been identified as a national problem. Dr. Hassler would like you to know that it is our policy to properly determine appropriate uses of Personal Health Information in accordance with the government rules, laws and regulations.

Because we believe there is always room for improvement. Our policy is to listen to our patients if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problems so that we may remedy the situation promptly.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office contact **Paul Gilea**, Office Manager at 415-397-0700 or write to 870 Market Street, Suite 600, San Francisco, CA 94102. You will not be penalized for filing a complaint.

_____

HIPAA Compliance Officer

Office Policy

Effective immediately, we will continue to be fully compliant and adherent to the Department of Justice Regulations for controlled substance dispensing for follow-up appointments. Chronic illnesses/diagnoses such as HIV/AIDS, hypertension, diabetes will require frequent follow-up appointments.

1. Controlled schedule 2 substance medications opioids as Vicodin (hydrocodone), Norco, Percocet, Morphine, and amphetamines such Adderall, Vyvanse, dextro-amphetamine **require 90 day/3-month follow-up visit for refills. NO EXCEPTIONS.**

2. Controlled medications schedule 3 - 4 Lyrica, sleep/anti-anxiety medications such as Ambien (Zolpidem) Ativan (Lorazepam), Xanax (Alprazolam), Klonopin (Clonazepam), and all testosterone products such as Androgel, Testim, and injectable testosterone cypionate/enanthate require every **120 days/4-month follow-up visit for refills. NO EXCEPTIONS. Testosterone refills require current labs to complete prior authorizations.**

3. Chronic illness patients with diagnoses such as HIV/AIDS, diabetes, uncontrolled hypertension require follow-up appointments every **3-6 months.**

4. Per CDC Guidelines, PrEP patients require labs and appointments every 90 days (two in-person visits per year).

5. Missed appointments/late cancellations are set at $75. Please note, reminder calls are a courtesy from our office. Patients are responsible for their appointments.

Due to insurance requirements, referrals and prior authorizations are not always possible without a medical evaluation by a healthcare provider. Please expect to make an appointment for evaluation when requesting referral or prior authorizations.

_____ _____

Signature Date

_____

Printed Name

Authorization for Use and/or Disclosure of Patient Health Information

I Hereby Authorize: (Previous Physician)

Name of Disclosing Party _____

Address _____

City, State Zip _____

Telephone # _____ Fax # _____

OPTIMUS MEDICAL GROUP

Shawn K. Hassler, MD
870 Market Street, Suite 600
San Francisco, CA 94102-3014
P 415.397.0700

PLEASE DO NOT FAX MEDICAL RECORDS!!

Records and Information Pertaining To:

Patients Name _____
Last First Middle

Patients Date of Birth _____ Telephone # _____

Home Address _____
Street City, State Zip

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of the signature unless a different date is specified here _____(date)
Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
Specify Records: Check the box ☐ specify which type of information is to be disclosed: then sign and date your selection.

	Signature	**Date**
☐ Medical Information	_____	
☐ Psychiatric Information	_____	
☐ HIV/AIDS Test/Treatment	_____	
☐ Other Health Information	_____	
Specify Records to Disclose	_____	

A copy of this authorization is a valid as the original. Patient has a right to a copy of this authorization.

Patient's Signature _____ **Date** _____

Effective 7/1/2022
Optional Pre-Payment of Administration Fees

We are honored that you have entrusted your medical care to us. As you may know, the cost of operating an independent medical practice is substantial. Many primary care doctors now belong to large, impersonal medical groups or have transitioned to other business models. We pride ourselves on remaining an independent medical practice free of daily quotas and appointment time restrictions. We already practice in a mostly "no rush" personalized concierge-style.

However, our costs continue to rise, and we struggle to retain our high-quality, loyal support staff.

Therefore, we have adopted an **optional prepaid administration fee of $200 per year** for those of you who use our support services frequently. This is not a membership fee or concierge fee.

If you elect to enroll for the prepaid administration fee, services will include:

1. Refills for schedule 2 controlled substance prescriptions (opiate pain medications and stimulant medicines for ADD) between office visits at no additional cost. You must still maintain office visits per controlled substance prescription guidelines.
2. Forms and letters, including jury letters, FMLA, companion pet, letters of diagnosis, return to work, medical marijuana, etc. at no additional cost. Appointments must still be made outside standard medical visits for the completion of disability and FMLA forms, which are more involved.
3. Mailing of items that require postage such as lab slips, ancillary care forms, and letters at no additional cost. Otherwise, you will be required to retrieve these at the office.

If you elect NOT to enroll for the prepaid administration fee, the above items performed outside the context of an appointment will be:

1. $25 per schedule 2 (opiate, amphetamines) controlled substance prescription, mailed lab requisition, or other mailed form.
2. $25 per page for forms completed outside the context of an office visit.